PREMERA BLUE CROSS

Highlights of your Health Care Coverage

SEIU Local 775

Group Number: 1018385

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible. **Effective date: 8/1/2005**

MEDICAL PLAN	FOUNDATION - $150 DEDUCTIBLE
MEDICAL COST SHARE OPTIONS	**IN-NETWORK BENEFITS ONLY**
Individual Deductible PCY (Family Deductible 3x Individual)	$150 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%
Individual Out of Pocket Maximum PCY, Excludes Copay (Family OOP Max 3x Individual)	$1,500 PCY
Office Visit Cost Share	$15 Copay
COVERED SERVICES	
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION	
Preventive Office Visit ($300 PCY)	Office Visit Cost Share
Immunizations (Shared with Exam Limit)	Covered in Full
Health Education (HE) (Not Covered)	Not Covered
Diabetes Health Education (DE) (Unlimited)	Covered in Full
PROFESSIONAL CARE	
Professional Office Visit Including Urgent Care	$15 Copay
Inpatient Professional Services	Deductible/Coinsurance
Contraceptive management (Unlimited)	$15 Copay
DIAGNOSTIC SERVICE OPTIONS	
Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA, Preventive	Deductible/Coinsurance
Professional Diagnostic Imaging and Laboratory Services, Basic	Deductible/Coinsurance
Professional Diagnostic Imaging and Laboratory Services, Major	Deductible/Coinsurance
Mammography	Covered in Full
FACILITY CARE OPTIONS	
Inpatient Facility	$100 per Day up to 3 Days per Admit to $1,000 PCY
Outpatient Surgery Facility	Deductible/Coinsurance
Skilled Nursing Facility (60 days PCY)	$100 per Day up to 3 Days per Admit to $1,000 PCY
EMERGENCY CARE OPTIONS	
Emergency Care (Waive copay if admitted, always subject to deductible and coinsurance.)	$100 Copay, Deductible/Coinsurance
Ambulance Transportation	$50 Copay
Air Ambulance ($3,000 PCY)	$50 Copay

PCY = Per calendar year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge. This plan's benefits are designed to cover care from network providers only except as otherwise stated.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

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OTHER SERVICES	IN-NETWORK BENEFITS ONLY
Acupuncture (12 visits PCY)	$15 Copay
Chemical Dependency ($12,500 per 24 Months)	Covered as Any Other Service
Home Health Care (130 visits PCY)	Deductible/Coinsurance
Hospice (Inpatient: 10 days PCY; Respite: 240 hours PCY; 6 month limit)	Deductible/Coinsurance
Manipulations (spinal and other) (12 visits PCY)	$15 Copay
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro) and Orthotics (Orth) (MS: $5,000 PCY; ME: $5,000 PCY Shared with MS; Pro: $5,000 PCY Shared with MS; Orth: $300 PCY, Shared with ME)	Deductible/Coinsurance
Mental Health Inpatient Facility Care (10 days PCY)	$100 per day, no OOP Max
Mental Health Outpatient Professional Care (20 visits PCY)	$25 Copay
Rehab Inpatient Facility (30 days PCY)	$100 per Day up to 3 Days per Admit to $1,000 PCY
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PCY)	Covered as Any Other Service
Transplants ($250,000 per lifetime; combined inpatient and outpatient limit)	Covered as Any Other Service
Routine Vision Exam (1 PCY)	$15 Copay
Vision Hardware ($130 PCY)	Covered in Full
Routine Hearing Exam (1 PCY)	Exam - Office Visit Cost Share; Test - Covered in Full
LIFETIME MAXIMUM	$2,000,000

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Pharmacy Benefits

Tier 1 = Generic
Tier 2 = Brand

Below is a brief overview of what you can expect to pay for a prescription drug, depending on which "tier" category it falls under in the Preferred Drug List for your plan when using an In-Network Pharmacy. For more information on your pharmacy benefits, including Out-of-Network benefits, see your benefit booklet. To find out what tier applies to a specific medication, see our Preferred Drug List in your pharmacy packet or at www.premera.com.

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PHARMACY PLAN	**2-TIER RX PLANS - $10/50%**
OUTPATIENT PRESCRIPTION DRUGS	**Cost Share Category Tier 1/ Tier 2**
Retail Cost Shares Up to 30 day supply per prescription	$10/ 50%
Mail Cost Shares Up to 90 day supply per prescription	$20/45%
Individual Deductible PCY	$0
Out-of-Network Non-participating retail and mail pharmacies	Cost Share, then 40% (to allowable)
Out of Pocket Max	Unlimited
Annual Benefit Max	Unlimited

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